STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395891	A. BLDG: 00 B. WING:	06/08/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LAUREL VIEW VILLAGE STATE LICENSE NUMBER: **043702**	**2000 CAMBRIDGE DRIVE** **DAVIDSVILLE, PA 15928**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and a Civil Rights Compliance survey completed on June 8, 2023, it was determined that Laurel View Village was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0607 SS=D		F 0607		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0607 SS=D	Continued from page 1 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 0607	Residents 3 and 34 were found to be directly impacted by this finding. It was found that on May 9, 2023, a nursing note for resident 3 revealed that her left knee was reddened and painful. A nursing note dated May 16, 2023 revealed that her left knee remained swollen and that she was complaining of pain and guarding her knee. She had yellow green bruising noted from her knee to her inner thigh. X-ray results revealed an acute fracture of Resident 3s distal femur. There was no documented evidence that the facility conducted an investigation to rule out abuse or neglect as the cause. A nursing note for Resident 34 dated June 3, 2023, revealed that the resident had a witnessed fall in her room while using the sit-to-stand lift machine. There was no documented evidence that the facility conducted a thorough investigation to rule out abuse or neglect as the cause of Resident 34s fall while using the sit-to-stand lift. Remedy could not be immediate as	Completion Date: **08/06/2023** Status: **APPROVED** Date: **06/23/2023**

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F 0607 SS=D	Continued from page 2 This REQUIREMENT is not met as evidenced by:	F 0607	the incident occurred in the past. All current Healthcare staff were assigned the Abuse Policy to acknowledge in Policy Stat (Laurel View Village's online Policy Review Platform). All newly hired staff as well as agency staff to be educated on the prevention of abuse and neglect and the current reporting requirements. The Event/Incident Report policy located in Policy Stat was updated to include the requirement that all staff who are working in that hallway at the time the incident/ preceding shift if necessary is discovered complete a witness statement additionally that an intervention is in place. Added an Intervention Education after Incident form to ensure interventions for incidents are educated on and relayed in nursing report. This policy was assigned to all current Healthcare Staff for acknowledgement and to be reviewed with all newly hired staff as well as agency staff who enter the	

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F 0607 SS=D	Continued from page 3	F 0607	facility. All incidents will be brought to the Healthcare Leadership morning meeting the following business day Monday- Friday and next business day if the incident occurs on the weekend. At that time to be the interdisciplinary team to determine appropriate intervention, Root Cause Analysis and any additional concerns or reporting needed. The Director of Nursing, Assistant Director of Nursing, Administrator, or other Healthcare Administration designee will conduct audits of incidents to ensure that the proper investigations were conducted. Audits are to be performed weekly for three months, then monthly for two quarters. On-the-spot education will be provided to staff as needed. The results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and	

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F 0607 SS=D	Continued from page 4	F 0607	Performance Improvement Committee for two quarters for further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting.	

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F 0607 SS=D	Continued from page 5 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to complete an investigation into an injury of unknown origin for two of 27 residents reviewed (Residents 3, 34) to rule out abuse/neglect as a possible cause. Findings include: The facility's policy regarding abuse prevention, dated November 2022, indicated that staff will report all alleged violations involving neglect or abuse, including injuries of unknown source. All alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in process. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3 dated, May 9, 2023, indicated that the resident was cognitively impaired, required extensive assistance with daily care needs	F 0607		

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F 0607 SS=D	Continued from page 6 including transfers, and had diagnoses that included Alzheimer's disease. A nursing note for Resident 3, dated May 9, 2023, at 2:24 p.m. revealed that her left knee was reddened and painful. A nursing note for Resident 3, dated May 16, 2023, at 9:11 a.m. revealed that her left knee remained swollen and that she was complaining of pain and guarding her knee. She had yellow/green bruising noted from her knee to her inner thigh. X-ray results revealed an acute fracture of Resident 3's distal femur (thigh bone near the knee). There was no documented evidence that the facility conducted an investigation to rule out abuse or neglect as a cause of Resident 3's leg fracture. An interview with the Nursing Home Administrator on June 8, 2023, at 9:45 a.m. confirmed that the facility did not conduct an investigation to rule out abuse or neglect as a cause of Resident 3's fracture.	F 0607		

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F 0607 SS=D	Continued from page 7 A quarterly MDS for Resident 34, dated May 16, 2023, indicated that the resident was cognitively impaired, required extensive assistance with daily care needs including transfers, and had diagnosis that included Alzheimer's disease, osteoarthritis, and abnormal posture. A nursing note for Resident 34, dated June 3, 2023, revealed that the resident had a witnessed fall in her room while using the sit-to-stand lift machine. The resident was attached to the right side of the lift with the sling underneath the resident when she slid out of her chair and onto the floor underneath the lift machine. There was no documented evidence that the facility conducted a thorough investigation to rule out abuse or neglect as the cause of Resident 34's fall while using the sit-to-stand lift. An interview with the Nursing Home Administrator on June 8, 2023, at 1:47 p.m. confirmed that the	F 0607		

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F 0607 SS=D	Continued from page 8 facility did not conduct a thorough investigation to rule out abuse or neglect as the cause of Resident 34's fall while using the sit to stand lift. 42 CFR 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(j) Resident rights 28 Pa. Code 211.12(d)(5) Nursing services	F 0607		
F 0609 SS=D		F 0609		

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F 0609 SS=D	Continued from page 9 483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0609	Residents 3 and 34 were found to be directly impacted by this finding. It was found that on May 9, 2023, a nursing note for resident 3 revealed that her left knee was reddened and painful. A nursing note dated May 16, 2023 revealed that her left knee remained swollen and that she was complaining of pain and guarding her knee. She had yellow green bruising noted from her knee to her inner thigh. X-ray results revealed an acute fracture of Resident 3s distal femur. There was no documented evidence that the facility reported the incident to the Pennsylvania Department of Health. This injury did not occur as a result from a resident fall. A nursing note for Resident 34 dated June 3, 2023, revealed that the resident had a witnessed fall in her room while using the sit-to-stand lift machine. The resident slid from the sit-to-stand lift, to her wheelchair, and was assisted to the floor. There was no documented evidence that the facility reported the incident to	Completion Date: **08/06/2023** Status: **APPROVED** Date: **06/23/2023**

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F 0609 SS=D	Continued from page 10	F 0609	the Pennsylvania Department of Health. Remedy could not be immediate as the incident occurred in the past. The Event/Incident Report policy located in Policy Stat (Facility Electronic Policy Data base) was updated to include the requirement that all staff who are working in that hallway at the time the incident/ preceding shift if necessary is discovered, complete a witness statement. Added an Intervention Education after Incident form to ensure interventions for incidents are educated on and relayed in nursing report. The Process Mapping for determining if an event is reportable and the timeframes to the Pennsylvania Department of Health was added to the policy. This policy was assigned to all current Healthcare Staff for acknowledgement and to be reviewed with all newly hired staff as well as agency staff who enter the facility.	

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F 0609 SS=D	Continued from page 11	F 0609	All incidents will be brought to the Healthcare Leadership morning meeting the following business day Monday- Friday and next business day if the incident occurs on the weekend. At that time the interdisciplinary team will determine if the incident requires any additional reporting and interventions or to confirm reporting if it was required immediately. The Director of Nursing, Assistant Director of Nursing, Administrator, or other Healthcare Administration designee will conduct audits of incidents to ensure that incidents requiring reporting to the Pennsylvania Department of Health were reported and in a timely manner. Audits are to be performed weekly for three months, then monthly for two quarters. On-the-spot education will be provided to staff as needed. The results of these logs/audits along with a Root Cause Analysis of any	

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F 0609 SS=D	Continued from page 12	F 0609	identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting.	

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F 0609 SS=D	Continued from page 13 Based on review of state laws, facility policies and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that all alleged violations involving abuse were reported to the State Survey Agency (Department of Health) and to other state agencies in accordance with state law for two of 27 residents reviewed (Residents 3, 34). Findings include: The Older Adult Protective Services Act of November 6, 1987, amended by Act 1997-13, Chapter 7, Section 701, requires that all administrators or employees who have reasonable cause to suspect that a resident was a victim of sexual abuse, that abuse/neglect resulted in serious physical injury and/or serious bodily injury, or that a death was suspicious, were to make an immediate report to the Protective Services Agency, the Pennsylvania Department of Aging (PDA), and to law enforcement officials.	F 0609		

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F 0609 SS=D	Continued from page 14 The facility's policy regarding abuse, dated November 2022, revealed that allegations of actual or suspected abuse with injuries of unknown origin would be immediately reported to the registered nurse supervisor, attending physician, Director of Nursing, Nursing Home Administrator, and to other officials in accordance with state law, including the State Survey and Certification Agency (Department of Health). A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3 dated, May 9, 2023, indicated that the resident was cognitively impaired, required extensive assistance with daily care needs including transfers, and had diagnoses that included Alzheimer's disease. A nursing note for Resident 3, dated May 9, 2023, at 2:24 p.m. revealed that her left knee was reddened and painful.	F 0609		

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F 0609 SS=D	Continued from page 15 A nursing note for Resident 3, dated May 16, 2023, at 9:11 a.m. revealed that her left knee remained swollen and that she was complaining of pain and guarding her knee. She had yellow/green bruising noted from her knee to her inner thigh. X-ray results revealed an acute fracture of Resident 3's distal femur (thigh bone near the knee). There was no documented evidence that the Department of Health was notified about Resident 3's fall with fracture. An interview with the Nursing Home Administrator on June 8, 2023, at 9:45 a.m. confirmed that the incident with Resident 3's fall with fracture should have been reported to the Department of Health. A quarterly MDS for Resident 34, dated May 16, 2023, indicated that the resident was cognitively impaired, required extensive assistance with daily care needs including transfers, and had diagnoses that included Alzheimer's disease, osteoarthritis, and abnormal posture.	F 0609		

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F 0609 SS=D	Continued from page 16 A nursing note for Resident 34, dated June 3, 2023, revealed that the resident had a witnessed fall in her room while using the sit-to-stand lift machine. The resident was attached to the right side of the lift with the sling underneath the resident when she slid out of her chair and onto the floor underneath the lift machine. There was no documented evidence that a thorough investigation was completed in order to determine what caused Resident 34 to slide out of her chair while using the lift machine. An interview with the Nursing Home Administrator on June 8, 2023, at 1:47 p.m. confirmed that the facility did not investigate the incident regarding Resident 34 sliding to the floor during a transfer with a sit-to-stand lift. She stated she did not feel this incident should have been a reportable to the Department of Health. 42 CFR 483.13 - Resident Behavior and Facility	F 0609		

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	395891	A. BLDG: __00_____ B. WING: _____	06/08/2023

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F 0609 SS=D	Continued from page 17 Practices, 10-1-1998 edition. 28 Pa. Code 201.18(b)(1) Management.	F 0609		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 18 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Resident 16 was found to be directly impacted by this finding. It was found that resident 16 on May 30, 2023 was prescribed Keflex 500 milligrams every 8 hours for 21 administrations, apply betadine 10 percent external solution every evening shift until June 14, 2023, and to soak the left great toe in a half cup of Epsom salt and warm water, then swab with betadine solution every Monday, Wednesday and Friday until June 14, 2023 for left great toe wound infection. A review of the resident's care plan revealed it did not include any information or interventions related to the care needs for the toe infection or use of antibiotic medication. Remedy could not be immediate as the incident occurred in the past and the resident had completed the antibiotic course on June 7, 2023. An audit for appropriate care plans was completed with regards to residents who are ordered an	Completion Date: **08/06/2023** Status: **APPROVED** Date: **06/23/2023**

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F 0656 SS=D	Continued from page 19 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	antibiotic or have a diagnosed infection. The care plan policy was reviewed. All registered nurses, Healthcare nursing leadership, and agency registered nurses, and future new hires and agency staff to be educated on the care plan policy. All current staff assigned to acknowledge the Care Plan Policy in Policy Stat (Electronic Policy Review Software used by Laurel View). The Director of Nursing, Registered Nurse Assessment Coordinator, Infection Preventionist (Assistant Director of Nursing), or other licensed healthcare designee will conduct audits of antibiotic orders placed for all residents and a corresponding infection/antibiotic usage care plan. Audits are to be performed weekly for one month, then monthly for two months, then quarterly for two quarters. On-the-spot education will be provided to staff as needed. The	

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F 0656 SS=D	Continued from page 20	F 0656	results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting.	

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F 0656 SS=D	Continued from page 21 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to develop comprehensive care plans that included specific and individualized interventions to address the care needs for one of 27 residents reviewed (Resident 16). Findings include: The facility's policy for care planning, dated April 2023, indicated that the facility develops and implemented a comprehensive, person-centered care plan for each resident. Care plans shall incorporate goals and objectives that lead to the promotion and or maintenance of the resident's highest level of independence. Each resident would be provided with individualized goals that were measurable and based on resident needs. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated March 3, 2023,	F 0656		

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F 0656 SS=D	Continued from page 22 indicated that the resident was cognitively intact and required extensive assistance from staff with her bed mobility, transfers, dressing, toileting, and personal hygiene. An interview with Resident 16 on June 5, 2023, at 7:51 p.m. revealed that her toes were very painful and that she had an infection. A review of Resident 16's clinical record revealed a podiatry consult, dated May 30, 2023, indicating that the resident had a left toe wound infection and the resident and staff requested nail debridement. Physician's orders for Resident 16, dated May 30, 2023, included orders to administer 500 milligrams (mg) of Keflex (an antibiotic) every 8 hours for 21 administrations, apply betadine 10 percent external solution every evening shift until June 14, 2023, and to soak the left great toe in a half cup of Epsom salt and warm water, then swab with betadine solution every Monday, Wednesday and Friday until June 14, 2023.	F 0656		

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F 0656 SS=D	Continued from page 23 Review of Resident 16's care plan, initiated May 29, 2019, revealed that it did not include any information or interventions related to the care needs for the toe infection or use of antibiotic medication. An interview with the Director of Nursing on June 8, 2023, at 12:15 p.m. confirmed that Resident 16's care plan did not include anything regarding the care and treatment of the great left toe. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0656		
F 0756 SS=D		F 0756		

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F 0756 SS=D	Continued from page 24 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	Resident 8 was found to be directly impacted by this finding. It was found that for resident 8 on March 13, 2023 a monthly pharmacy medication regimen review revealed a recommendation for a gradual dose reduction of Seroquel from 25 milligrams to 12.5 milligrams daily. There was no documentation that a gradual dose reduction was completed at that time. A review of a monthly pharmacy medication review dated April 11, 2023 revealed a repeat recommendation for a gradual dose reduction of Seroquel from 25 milligrams to 12.5 milligrams daily. Physician's orders dated April 12, 2023 included an order for the resident to receive one 12.5 milligram tablet of Seroquel daily for dementia with behavioral disturbance. Remedy could not be immediate as resident was ordered the gradual dose reduction in April, 2023. Immediately reviewed the physician's practice of responding to suggestions with physician with the physician requesting to not change his current process where he reviews	Completion Date: **08/06/2023** Status: **APPROVED** Date: **06/23/2023**

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F 0756 SS=D	Continued from page 25 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756	suggestions daily Monday through Friday. The Psychotropic Medication Use Policy was updated to include tracking of physician response to recommendations made by the pharmacist. The updated policy was assigned to all Healthcare registered nurse supervisors for acknowledgement and will be reviewed with all new staff on hire as well as temporary registered nurse staff. All recommendations for gradual dose reductions from the pharmacist will be tracked on a spreadsheet for the timeliness of response from the physician. The physician will be recontacted for all recommendations not addressed after 2 business days. The Director of Nursing, Infection Preventionist (Assistant Director of Nursing), or other licensed healthcare designee will conduct audits of Consultant Pharmacist Recommendations and timeliness of physician response. Audits are to be performed monthly for three quarters.	

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F 0756 SS=D	Continued from page 26	F 0756	On-the-spot education will be provided to staff as needed. The results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting.	

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F 0756 SS=D	Continued from page 27 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the physician responded timely to a pharmacy recommendation for one of 27 residents reviewed (Resident 8). Findings include: The facility's policy regarding consultant pharmacist services provider requirements, dated May 2023, revealed that at least monthly the resident's medication regimen would be reviewed by the consultant pharmacist. The reviews would address standards of care which may include issues related to federal regulations, drug interactions, drug side effects, dosage adjustments or reductions, alternative therapy, and lab requirements. The documentation will be noted in the facility's electronic medical record and issues of note will be provided to the responsible provider, Director of Nursing, and Medical Director with a written summary. The facility has a process to ensure that issues are acted upon in a timely manner relative to	F 0756		

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F 0756 SS=D	Continued from page 28 the degree of significance. Physician's orders for Resident 8, dated September 7, 2022, included an order for the resident to receive one 25 milligram (mg) tablet of Seroquel (antipsychotic medication) daily for dementia with behavioral disturbance. A monthly pharmacy medication regimen review for Resident 8, dated March 13, 2023, revealed a recommendation for a gradual dose reduction of Seroquel from 25 mg to 12.5 mg daily. There was no documented evidence that a gradual dose reduction was completed. A monthly pharmacy medication regimen review for Resident 8, dated April 11, 2023, revealed a repeat recommendation for a gradual dose reduction of Seroquel from 25 mg to 12.5 mg daily. Physician's orders for Resident 8, dated April 12, 2023, included an order for the resident to receive one 12.5 mg tablet of Seroquel daily for dementia with behavioral disturbance.	F 0756		

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F 0756 SS=D	Continued from page 29 Interview with the Nursing Home Administrator on June 8, 2023, at 12:29 p.m. confirmed that there was no documented evidence in Resident 8's clinical record to indicate that the physician addressed the March 13, 2023, pharmacy recommendation for a gradual dose reduction of Seroquel until April 12, 2023, when it was recommended a second time. 28 Pa. Code 211.12(d)(3)(5) Nursing services.	F 0756		
F 0758 SS=D		F 0758		

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F 0758 SS=D	Continued from page 30 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	Resident 8 was found to be directly impacted by this finding. It was found that for resident 8 on March 13, 2023 a monthly pharmacy medication regimen review revealed a recommendation for a gradual dose reduction of Seroquel from 25 milligrams to 12.5 milligrams daily. There was no documentation that a gradual dose reduction was completed at that time. A review of a monthly pharmacy medication review dated April 11, 2023 revealed a repeat recommendation for a gradual dose reduction of Seroquel from 25 milligrams to 12.5 milligrams daily. Physician's orders dated April 12, 2023 included an order for the resident to receive one 12.5 milligram tablet of Seroquel daily for dementia with behavioral disturbance. Remedy could not be immediate as resident was ordered the gradual dose reduction in April, 2023. Facility followed physicians recommendations once written.	Completion Date: **08/06/2023** Status: **APPROVED** Date: **06/23/2023**

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F 0758 SS=D	Continued from page 31 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	Immediately reviewed the physician's practice of responding to suggestions with physician with the physician requesting to not change his current process where he reviews suggestions daily Monday through Friday. A sample of other GDR's were reviewed and addressed in a timely manner. Facility and Medical Director consider this an isolated incident. The Psychotropic Medication Use Policy was updated to include tracking of physician response to recommendations made by the pharmacist. Definition of "timeliness" was clarified in policy. The updated policy was assigned to all Healthcare registered nurse supervisors for acknowledgement and will be reviewed with all new staff on hire as well as temporary registered nurse staff. All recommendations for gradual dose reductions from the pharmacist will be tracked on a spreadsheet for	

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LAUREL VIEW VILLAGE STATE LICENSE NUMBER: **043702**	**2000 CAMBRIDGE DRIVE** **DAVIDSVILLE, PA 15928**

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F 0758 SS=D	Continued from page 32	F 0758	the timeliness of response from the physician. The physician will be recontacted for all recommendations not addressed after 2 business days and documentation of that contact will be made in residents Electronic Medical Record. The Director of Nursing, Infection Preventionist (Assistant Director of Nursing), or other licensed healthcare designee will conduct audits of Consultant Pharmacist Recommendations and timeliness of physician response. Audits are to be performed monthly for three quarters. On-the-spot education will be provided to staff as needed. The results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting.	

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F 0758 SS=D	Continued from page 33 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the physician responded timely to pharmacy recommendations for one of 27 residents reviewed (Resident 8). Findings include: The facility's policy regarding consultant pharmacist services provider requirements, dated May 2023, revealed that at least monthly the resident's medication regimen would be reviewed by the consultant pharmacist. The reviews would address standards of care which may include issues related to federal regulations, drug interactions, drug side effects, dosage adjustments or reductions, alternative therapy, and lab requirements. The documentation will be noted in the facility's electronic medical record and issues of note will be provided to the responsible provider, Director of Nursing, and Medical Director with a written	F 0758		

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F 0758 SS=D	Continued from page 34 summary. The facility has a process to ensure that issues are acted upon in a timely manner relative to the degree of significance. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated May 12, 2023, indicated that the resident was cognitively impaired and required extensive assistance from staff with her bed mobility, transfers, dressing, toileting, personal hygiene, and received antipsychotic medication. Physician's orders for Resident 8, dated September 7, 2022, included an order for the resident to receive one 25 milligram (mg) tablet of Seroquel (antipsychotic medication) daily for dementia with behavioral disturbance. A monthly pharmacy medication regimen review for Resident 8, dated March 13, 2023, revealed a recommendation for a gradual dose reduction of Seroquel from 25 mg to 12.5 mg daily. There was no documented evidence that a gradual dose	F 0758		

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F 0758 SS=D	Continued from page 35 reduction was completed. A monthly pharmacy medication regimen review for Resident 8, dated April 11, 2023, revealed a repeat recommendation for a gradual dose reduction of Seroquel from 25 mg to 12.5 mg daily. Physician's orders for Resident 8, dated April 12, 2023, included an order for the resident to receive one 12.5 mg tablet of Seroquel daily for dementia with behavioral disturbance. A review of the medication administration record for Resident 8 for March and April 2023 revealed that 25 mg of Seroquel was administered from March 13-24, 2023, and March 31 to April 11, 2023. Resident 8 was on hospital leave from March 25-30, 2023. Interview with the Nursing Home Administrator on June 8, 2023, at 12:29 p.m. confirmed that there was no documented evidence that Resident 8's physician addressed the pharmacist's recommendation from March 13, 2023, to decrease	F 0758		

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F 0758 SS=D	Continued from page 36 the resident's Seroquel and the resident continued to receive 25 mg daily until April 11, 2023. 28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0758		
F 0804 SS=F		F 0804		

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F 0804 SS=F	Continued from page 37 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 0804	Immediately upon observation: It was determined that the steam table was not holding temperatures, A Maintenance Evaluation was completed immediately to determine the issue, it was determined it was not holding temp. Food Temperatures were obtained multiple times during meal service and recorded, to ensure the temperatures remained appropriate. A new steam table was ordered, until delivery can occur. Hot water from the urn is poured into the wells immediately before service. All meal service food is not put into the steam table until immediately before service. During this process Food Temperatures were obtained to ensure compliance for the duration of meal service. Reeducation provided to Dining Services staff regarding this regulation as well as the Policy of Laurel View Village regarding Food Temperatures and the process should a concern be identified.	Completion Date: **08/06/2023** Status: **APPROVED** Date: **06/23/2023**

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F 0804 SS=F	Continued from page 38	F 0804	Logs on the steam wells with an infrared thermometer will be completed by The Dining Services Team. The Dining Services Director, Executive Chef and/or Designee will review these logs. Audits will be completed in the following schedule. Three meals a day, seven days a week for two weeks. Three meals a day, three days a week for two weeks. Three meals a day, one day and as needed for two weeks. On-the-spot education will be provided to staff as needed. The results of these audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting.	

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F 0804 SS=F	Continued from page 39 Based on a review of facility policy, resident interviews, observations, and staff interviews, it was determined that the facility failed to ensure that residents received foods that were served at appetizing temperatures. Findings include: The facility's policy regarding Meal Temperatures, dated November 2022, revealed that all food and drinks should be palatable, attractive and served at a safe and appetizing temperature. Interview with Resident 44 on June 6, 2023, at 9:47 a.m. revealed that the food served by the facility at meal times was not served hot enough, tasted cold, and the plates were cold. Observations in the dining room kitchenette on June 7, 2023, at 11:53 a.m. revealed Dietary Worker 2 was plating food from the steam table and then placing the plate into microwave for 30 seconds	F 0804		

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F 0804 SS=F	Continued from page 40 prior to serving it to the residents. A test tray was requested from the kitchenette on June 7, 2023, at 12:30 p.m. after the last of the residents had been served. The test tray was served from the steam table and was not placed into the microwave as each of the other trays had been. At 12:34 p.m. the test tray temperature of the carrots was 101.9 degrees F, the temperature of the mashed potatoes with gravy was 112.1 degrees F, the temperature of the pork loin with gravy was 126.1 F, and these items were cold to taste and not appetizing at the temperatures they were served at. An interview with Dietary Worker 2 on June 7, 2023, at 12:34 p.m. revealed that she plates the food from the steam table but puts each plate in the microwave because the residents like their food hot. She did not know if the steam table was functioning properly or not. An interview with the Dietician on June 7, 2023, at 12:41 p.m. confirmed that the carrots, mashed	F 0804		

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F 0804 SS=F	Continued from page 41 potatoes and pork loin were not served at proper temperatures, and that she did not know if the steam table was functioning properly. An interview with the Dietary Manager on June 7, 2023, at 3:11 p.m. revealed that the steam table was not functioning properly and that they were going to get it repaired. She stated that the food temperatures at lunch were too low. 28 Pa. Code 201.18(b)(1)(e)(1) Management.	F 0804		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 42 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	Immediately upon observation, Expired and outdated milk was thrown out, an audit of the milk cooler was completed with no additional expired products found. The milk vendor was made aware of the milk received without expiration dates stamped on them. To ensure this from occurring going forward, Education will be completed with dining services staff who are present during delivery reconciliation reject any milk without proper date ranges. A designated spot marked in the walk-in cooler will be for expired milk to be tracked and thrown away by dining services management. Education will be completed with Dining Services staff regarding the delivery of products with proper manufacturing and expiration dates being present and within range. Logs will be completed twice a week or with milk delivery by the Dining Services Team. The Dining Services	Completion Date: **08/06/2023** Status: **APPROVED** Date: **06/23/2023**

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F 0812 SS=F	Continued from page 43	F 0812	Director, Executive Chef and/or Designee will review these logs. On-the-spot education will be provided to staff as needed. The results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting.	

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F 0812 SS=F	Continued from page 44 Based on observations and staff interviews, it was determined that the facility failed to store and prepare food under sanitary conditions. Findings include: Observations of the grill and deep fryer on June 5, 2023, at 6:58 p.m. revealed a large accumulation of a thick, blackened, removable substance on the grill, food debris and crumbs around the grill, and grease splashes down the sides of the grill. The deep fryer had food debris/crumbs piled up in the grease and grease stains around the fryer. Observations of the prep cooler on June 5, 2023, at 6:58 p.m. revealed three half-pint cartons of milk that expired on May 19, 2023, and eight half-pint cartons of milk that had no expiration date printed on them. Interview with the Dietary Manager on June 5, 2023, at 6:58 p.m. confirmed that the grill and deep	F 0812		

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F 0812 SS=F	Continued from page 45 fryer were in need of cleaning and that the expired milk and the milk cartons without an expiration date should have been thrown out. 28 Pa. Code 211.6(f) Dietary services.	F 0812		
F 0849 SS=E		F 0849		

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F 0849 SS=E	Continued from page 46 483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 0849	Immediately, the identified person responsible for contacting the hospice within Laurel View was interviewed. She was able to provide documentation on her multiple attempts to obtain these records from the identified Hospice since February of 2023. The Director of Nursing and Registered Nurse Supervisor contacted the identified Hospice, during the survey, to obtain records for Resident 3. Documentation was provided on Wednesday (June 7, 2023); however, the documentation was still missing the required information. The Director of Nursing then contacted Hospice again to provide documentation which arrived the morning of Thursday (June 8, 2023) . All other Hospice Records were immediately reviewed with no missing documentation found. The identified Hospice Executive Director was contacted by Laurel View Administrator and made aware	Completion Date: **08/06/2023** Status: **APPROVED** Date: **06/23/2023**

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F 0849 SS=E	Continued from page 47 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and	F 0849	of the lack of fulfilling their contractual obligations as well as requirements through the state and per Laurel View Policy and Standard Expectation. The full contract will be terminated at the end of service to Resident 3. The Hospice policy was reviewed. All Hospice Agencies, registered nurses, Healthcare nursing leadership, agency registered nurses, Medical Records, and future new hires to be educated on the requirement that: records will be prepared and maintained with federal and state law, rules, regulations, procedures, policies, guidelines, and generally accepted medical record practices. A record of all services provided to the patient and events regarding the patient's care will be located at the facility. Current Hospice Agencies check in with the Registered Nurse Supervisor and/or Director of Nursing/Assistant Director of Nursing following their visits and	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0849 SS=E	Continued from page 48 drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and	F 0849	leave copies of their documentation at the facility in real time. No documentation is waiting to be returned. The Nursing Home Administrator, Director of Nursing, Registered Nurse Assessment Coordinator, Infection Preventionist (Assistant Director of Nursing), or other licensed healthcare designee will conduct audits of Hospice charts for all residents receiving services. Audits are to be performed weekly for one month, then monthly for two months, then quarterly for two quarters. On-the-spot education will be provided to Laurel View staff and Hospice Staff as needed. The results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for	

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	395891	A. BLDG: __00_____ B. WING: _____	06/08/2023

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F 0849 SS=E	Continued from page 49 capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any)	F 0849	further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting.	

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F 0849 SS=E	Continued from page 50 orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by:	F 0849		

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F 0849 SS=E	Continued from page 51 Based on review of hospice contracts and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the designated interdisciplinary team member obtained the required information from the contracted hospice provider for one of 27 residents reviewed (Resident 3) who was receiving hospice services. Findings include: An agreement between the facility and a hospice provider (provider of end-of-life services) indicated that the hospice provider would maintain medical records for each hospice patient. Such records will be prepared and maintained with federal and state law, rules, regulations, procedures, policies, guidelines, and generally accepted medical record practices. A record of all services provided to the patient and events regarding the patient's care will be located at the facility. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and	F 0849		

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F 0849 SS=E	Continued from page 52 care needs) for Resident 3 dated, May 9, 2023, indicated that the resident was cognitively impaired, required extensive assistance with daily care needs including transfers, was receiving hospice services, and had diagnosis that included Alzheimer's disease. Physician's orders for Resident 3, dated February 2, 2023, revealed that the resident was to receive hospice services from the facility's contracted hospice provider. As of June 9, 2023, there was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained updated nursing notes from hospice. The last nursing note from hospice located on the resident's chart was dated February 7, 2023. Interview with Registered Nurse 1 on June 7, 2023, at 1:35 p.m. confirmed that there were no updated nursing notes on Residents 3 hospice binder and that the last note was dated February 7, 2023. Interview with the Nursing Home Administrator on June 7, 2023, at 3:29 p.m. confirmed that Resident	F 0849		

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F 0849 SS=E	Continued from page 53 3 did not have updated nursing notes on the hospice chart and that there should have been. 28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0849		
F 0867 SS=D		F 0867		

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F 0867 SS=D	Continued from page 54 483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including	F 0867	The current Quality Assurance Performance Improvement program has been reviewed by the Director of Quality and Compliance. The repeat deficiencies have been reviews and audits have been developed to provide accurate data collection and process improvement. Director of Quality and Compliance will review Quality Assurance and Performance Improvement Minutes. Education has been provided to the Interdisciplinary Team Regarding Repeat deficiencies. Audits for repeat deficiencies will be completed per their individual plan of corrections. All audits will be reviewed at Quality Assurance and Performance Improvement Quarterly meeting where a Root Cause Approach will Evaluate new and recurrent deficiencies. Revision or extension of audits will be discussed with the Interdisciplinary Team. Any audits that need to be reviewed will be done at that time.	Completion Date: **08/06/2023** Status: **APPROVED** Date: **06/23/2023**

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F 0867 SS=D	Continued from page 55 the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the	F 0867		

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F 0867 SS=D	Continued from page 56 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867		

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F 0867 SS=D	Continued from page 57 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: [redacted] 28 Pa. Code 201.18(e)(1) Management of licensee.	F 0867		

Certified End Page

LAUREL VIEW VILLAGE

STATE LICENSE NUMBER: 043702

SURVEY EXIT DATE: 06/08/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY